

STATE OF MICHIGAN

RICK SNYDER GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES DIVISION OF CHILD WELFARE LICENSING

NICK LYON DIRECTOR

February 16, 2018

Nathan Cox Starr Commonwealth 13725 Starr Commonwealth Albion, MI 49224-9580

RE: License #: CI130201440 Investigation #: **2018C0103013**

Starr Commonwealth

Dear Mr. Cox:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- For any repeat violations, include an assessment of why the previous corrective action plan was ineffective.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9740.

FOR CWL ONLY

Please note that violations of any licensing rules are also violations of the MSA and your contract.

Sincerely,

Rorie Dodge-Garnaat, Licensing Consultant MDHHS\Division of Child Welfare Licensing 235 Grand, Ste 407 P.O. Box 30650 Lansing, MI 48909

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(517) 899-6024

enclosure

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES DIVISION OF CHILD WELFARE LICENSING SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	CI130201440
Investigation #:	2018C0103013
Complaint Receipt Date:	11/30/2017
Complaint Receipt Date:	11/30/2017
Investigation Initiation Date:	12/06/2017
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Report Due Date:	01/29/2018
Licensee Name:	Starr Commonwealth
Licensee Address:	13725 Starr Commonwealth
Licensee Address.	Albion, MI 49224
	7 (IOIOII), WII 1022 I
Licensee Telephone #:	(517) 629-5591
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Administrator:	Elizabeth Carey, Designee
Lisana Basima	File Latt Occur Bustiness
Licensee Designee:	Elizabeth Carey, Designee
Name of Facility:	Starr Commonwealth
Traine or Facility.	Gtair Gommonwounin
Facility Address:	13725 Starr Commonwealth
	Albion, MI 492249580
Facility Talankana #	(547) 000 5504
Facility Telephone #:	(517) 629-5591
Original Issuance Date:	04/01/1991
July 1904an 1904an	
License Status:	REGULAR
Effective Date:	09/02/2016
Expiration Data:	09/01/2018
Expiration Date:	03/01/2010
Capacity:	240
Program Type:	CHILD CARING INSTITUTION, PRIVATE

II. ALLEGATION(S)

Violation	
Established'	•

A staff went to sit a resident down in a chair. The resident fell onto	Yes
a mop bucket and broke his finger.	

III. METHODOLOGY

11/30/2017	Special Investigation Intake 2018C0103013
12/06/2017	Special Investigation Initiated - On Site
12/14/2017	Contact - Face to Face Youth A, Youth B, and Mr. Urquhart
12/20/2017	Contact - Face to Face Reviewed Case file and personnel file
12/20/2017	Inspection Completed-BCAL Sub. Compliance
12/20/2017	Exit Conference

ALLEGATION:

A staff went to sit a resident down in a chair. The resident fell onto a mop bucket and broke his finger.

INVESTIGATION:

11/30/17; phone call from James. He stated a staff member was trying to separate two kids to keep them from fighting. The staff said he went to separate them and one of the residents tripped and fell. The youth and witnesses state the staff was trying to sit the resident down when the resident hit the mop bucket and broke his thumb.

James said it had not been called in. He had questions as to whether it should be called in and this consultant told him if the staff did not perform an appropriate restraint and the resident was hurt then they needed to call it in.

Youth A was interviewed at the facility on 12/14/17. He stated he and Youth B got into a physical altercation and Mr. Urquhart separated them. He said this occurred on a Sunday. Mr. Urquhart grabbed Youth B and pushed him into a chair by the window. Youth A tried to go after Youth B and Mr. Urquhart grabbed Youth A by the collar of the shirt and sat him in the chair. Youth A got up from the chair and Mr. Urquhart put him back into the chair. On his way down Youth A slipped and fell, tripping over the mop bucket and landing on his thumb. Urquhart held Youth A in a restraint. After the restraint Youth A told Mr. Urquhart that his thumb hurt. Mr. Urquhart told Youth A it probably was not broken and told him to put ice on it. Youth A said he went to the clinic the following day then was sent to Urgent Care two days later. Youth A said Mr. Urquhart did what he had to do and Youth A does not blame him for the injury to his thumb.

Youth Specialist Dennis Urquhart was interviewed. He stated it was shower time. He was monitoring the kitchen and living room when he heard Youth A and Youth B arguing. Mr. Urquhart separated the two boys by putting his body in front of Youth B. He said he did not grab either boy. He was able to get Youth B to go into another room but Youth A ran in after him. Mr. Urquhart went to move Youth A by placing his arm up on the side of Youth A and guiding him back. Youth A then tripped on the mop bucket and fell. Afterwards Youth A said his thumb hurt.

Youth B was next to be interviewed. He stated he was playing cards when he heard Youth A arguing with another peer. Youth B laughed at Youth A. Youth A then went up to him and began to yell at him. Youth A got into Youth B's face and Youth B punched him. Mr. Urquhart pushed the boys to different sides of the room. Youth B said Mr. Urquhart grabbed him by the shoulders and moved him to a chair. Youth B said he sat in the chair on his own. Youth B said Mr. Urquhart forced Youth A into the chair in order to keep him from Youth B. Youth A then fell out of his chair and onto the mop bucket.

Mr. Urquhart's personnel file was viewed. The file contained all necessary training and did not list any notable disciplines.

Youth A's medical file was reviewed. The file indicated that he was seen by the nurse in the clinic on 11/27/17 and he went to Urgent Care the following day. Youth A was diagnosed with a fractured right thumb.

The Unusual Incident Report (UIR) written by Mr. Urquhart on 11/26/17 stated Youth A and Youth B were arguing then Youth B hit Youth A so Mr. Urquhart separated them. When Mr. Urquhart went to move Youth A he tripped over the mop bucket and both him and Youth A fell.

Nothing in the Facility's Behavior Management Policy or Training Materials for Safe Crisis Management (SCM), the facility's behavior management technique, indicates that staff can force a resident to sit down in a chair.

APPLICABLE RULE		
R 400.4157	Behavior management.	
	(1) An institution shall establish and follow written policies and procedures that describe the institution's behavior management system. The policies and procedures shall be reviewed annually and updated as needed. These shall be available to all residents, their families, and referring agencies.	
ANALYSIS:	Based on Youth A and Youth B's interviews Mr. Urquhart utilized an unapproved technique to force Youth A into a chair.	
CONCLUSION:	VIOLATION ESTABLISHED	

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan it is recommended this investigation be closed with no further licensing action.

Kon Likelige-Sarnaa	2/12/18
Rorie Dodge-Garnaat Licensing Consultant	Date
Approved By:	
Claudia Str	February 16, 2018
Claudia Triestram Area Manager	Date